## DISABILITY/HANDICAPPED STATUS VERIFICATION

TO:		RE:	
			Name
FRON	v <b>ı</b> :		Social Security Number
			Thank you for your prompt response. All information is confidential.  Please contact
			at ( ) if you have any questions.
	lo not have to sign this form if either the requesting organization o	r the or	R RELEASE OF INFORMATION ganization supplying the information is left blank. on obtained under this consent is limited to information that is no older than 12 months. There
are ci	·		o to 5 years old, which would be authorized by me on a separate consent, attached to a copy of
	Signature		 Date
Act,			ot the applicant is disabled as defined in Section 223 of the Social Security ces and Facilities Construction Amendment of 1970, or as defined in 24 CFR
A.	, ,	•	eason of any medically determinable physical or mental Yes 🔲 🖽 No 🖂 ch has lasted or can be expected to last for a continuous
В.		ss to e	d is blind (within the meaning of "blindness" as defined in Yes No no engage in substantial gainful activity in which he/she has period of time.
C.	A disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition of an individual Yes No found by the Secretary (of Health, Education, and Welfare) to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains age twenty-two, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.		
D.	A handicapped person as defined in 24 CFR Section 5.403: a person having a physical or mental impairment which (1) is Yes $\square$ No $\square$ expected to be of long-continued and indefinite duration, (2) substantially impedes his/her ability to live independently, and (3) is of such nature that such a disability could be improved by more suitable housing conditions.		
If yo	u are unable to complete this form, please indicate re	ason: _	
l cer	tify that this form is completed in response to a direc	t and e	explicit request of the patient.
Doct	cor's Name (Print or type)		Signature of Doctor
(	)		-
Telei	phone Number		Date

PENALTIES FOR MISUSING THIS CONTENT: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a), (6), (7) and (8).